Appendix 1

National HCFA 1500 Claim Form Completion Instructions for Child Care Coordination Services

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate.

Providers are not required to bill commercial health insurance for child care coordination services.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1— Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid ID number. Do not enter any other numbers or letters.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid ID card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Element 10 — Is Patient's Condition Related to (not required)

Element 11— Insured's Policy, Group, or FECA Number (not required)

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Appendix 1
(Continued)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the appropriate diagnosis code as follows:

- Enter V61.8 (other specified family circumstances) if the Family Questionnaire indicates the recipient to be high risk (a score of 70 or more points on the Family Questionnaire). Procedure codes W7096 and W7097 are only allowable if V61.8 is indicated.
- Enter V61.9 (unspecified family circumstances) if the Family Questionnaire indicates the recipient is not high risk (a score of fewer than 70 points on the Family Questionnaire).

Element 22 — Medicaid Resubmission (not required)

Element 23 —- Prior Authorization Number (not required)

Element 24A — Date(s) of Service

For ongoing care coordination and monitoring (W7097), if the service was performed on more than one date of service within the month, indicate the last date the service was performed. If billing for more than one month of activities, use one detail line for each month's activities with the date of service determined as described below. Refer to Appendix 2 of this handbook for a completed sample claim form that shows more than one month's activities billed on the same claim form.

Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the last date of service in MM/DD/YY or MM/DD/YYYY format in the "From" field.

Element 24B — Place of Service

Enter the appropriate Medicaid single-digit place of service (POS) code for each service. Enter 0 (other) if the place of service occurred in more than one location. Refer to Appendix 5 of this handbook for Medicaid-allowable POS codes.

Element 24C — Type of Service

Enter "9" as the single-digit type of service code.

Appendix 1
(Continued)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code (refer to Appendix 4 of this handbook for a list of Medicaid-allowable procedure codes). Claims received without an appropriate procedure code are denied by Wisconsin Medicaid.

Modifiers

Enter the appropriate two digit procedure code modifier in the "Modifier" column of Element 24D when billing for the initial risk assessment (Family Questionnaire). Refer to Appendix 4 of this handbook for definitions of modifiers.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of hours billed on each line. Round to the nearest 0.1 hour. Appendix 6 of this handbook lists the rules for rounding. Always enter "1.0" when billing procedure codes W7095 and W7096.

Element 24H — EPSDT/Family Planning (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No.

Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status (R/S) Report.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due

Enter the balance due. This will be the same amount as appears in Element 28.

Appendix 1
(Continued)

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.